

# EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

## REASON FOR REPORT (check all that apply)

- 2a. ☐ LOST TIME - ONE OR MORE DAYS  
 3. ☐ LOST EARNINGS BUT NO LOST TIME  
 6a. ☐ OCCUPATIONAL DISEASE  
 7a. ☐ CORRECT PRIOR REPORT
- 2b. WAS EMPLOYEE PAID FOR 1/2 DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO  
 4. ☐ MEDICAL/HEALTH CARE  
 5. ☐ FATALITY DATE OF DEATH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MM DD YYYY  
 6b. DATE OF LAST EXPOSURE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MM DD YYYY  
 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MM DD YYYY  
 7b. DATE OF CORRECTION: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MM DD YYYY  
 7c. DATE CORRECTION SENT TO WCB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MM DD YYYY

## EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):		9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O. BOX MAILING ADDRESS:		12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:		17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:		18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:	

(check one) ☐ **INSURER** ☐ **THIRD PARTY ADMINISTRATOR (TPA)** ☐ **SELF-ADMINISTERED**

19. INSURANCE / TPA COMPANY NAME:		20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:		23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

## EMPLOYEE

27. LAST NAME:		28. FIRST NAME:		29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER:	32. GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:		34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ____/____/____ MM DD YYYY	
38. OCCUPATION/JOB TITLE:		39. DATE OF HIRE: ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: \$		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS:		

## CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY		43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY		44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):		45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY	
DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY		DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY		46. TIME OF INJURY (e.g. 1:10 p.m.):		47. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE: ____/____/____ MM DD YYYY	

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(S) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING AT THE TIME EVENT OCCURRED (e.g. acetylene torch, metal plate):
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51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring):	52. HOW THE INJURY OR ILLNESS OCCURRED DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SURFACES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on smooth metal. As worker fell, worker brushed against hot metal.):
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53. HOSPITALIZED OVERNIGHT AS INPATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	54. HEALTH CARE PROVIDER NAME:	55. MAILING ADDRESS:	56. TELEPHONE NUMBER: ( )
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## PREPARER INFORMATION

57. PREPARER NAME AND TITLE (TYPE OR PRINT):	58. TELEPHONE NUMBER: ( )	59. DATE SENT TO WCB: ____/____/____ MM DD YYYY
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